C-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Feb/28/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Purchase of External Bone Growth Stimulator

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon,
Board Certified Spine Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[ ] Upheld (Agree)

[X] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Adverse Determination Letters, 1/7/10, 1/13/10
Back Institute 2/1/10, 6/5/09, 10/29/09
Experts 12/3/09
Medical Center 1/4/10
M.D. 10/13/09
Official Disability Guidelines, Low Back

PATIENT CLINICAL HISTORY SUMMARY
This is an injured worker who has a diagnosis of herniated nucleus pulposus at C5/C6. He has undergone an anterior cervical discectomy and fusion with using allografts and cages along with instrumentation. He smokes a pack a day for the last twenty years, and according to the medical records, did not stop smoking prior to the operative intervention. The current request is for a bone growth stimulator.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
According to the Official Disability Guidelines, the criteria for use of noninvasive bone growth stimulator or an invasive stimulator include any of the following: one or more previous failed fusions, grade 3, with spondylolisthesis fused at more than one level, current smoking habit, comorbid medical conditions including diabetes renal disease, alcoholism, and significant osteoporosis. Given the fact that this patient is a twenty-year smoker at a pack a day, he falls

into the Official Disability Guidelines and Treatment Guidelines criteria for a bone growth stimulator. It is for this reason that the previous adverse determination is overturned. The reviewer finds that medical necessity exists for Purchase of External Bone Growth Stimulator.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)